MEMORANDUM OF EVIDENCE

CHILD WELFARE CENTRES

Memorandum to the Subcommittee on Medical Functions and Staffing of Child Welfare Centres. Ministry of Health Standing Medical Advisory Committee

This memorandum has been prepared with the assistance of members and associates of the College who have previously expressed an interest in infant welfare; some are in active general practice; some in full-time public health; some divide their time between the two.

Historically, child welfare centres grew out of the milk depots which were set up at the latter end of the last century. At these depots, advice on infant feeding was given as a part of the campaign to deal with the problem of infant mortality. The high rate of this mortality had been exposed by the introduction of accurate registration of births, and the extent of the problem had been brought to light by the ' Ladies of Salford ' who were the forerunners of today's health visitors.

In 1918 the Child Welfare Act laid down the responsibility of the local authorities for these centres. As new aspects of child welfare arose, the functions of these centres were extended; for example, immunization against diphtheria was not generally introduced until the late 1930's. Pertussis, tetanus and polio vaccinations are extremely recent additions to the activities of these centres.

Child welfare centres have been and should remain part of the logical sequence which commences with the antenatal care of the expectant mother and is continued through the school health services.

Prior to 1948, the child welfare centres had often been viewed by the general practitioner as competition, for they offered, free of charge, that which he felt was part of his legitimate source of income. The position is altering, and today, in many areas, the activities of local authority child welfare centres have been amalgamated with the general-practitioner service. Health visitors are welcome in many practices, and in the future the co-ordination should be complete. The resentment which lingers on is unlikely to survive in those who first entered general practice after the advent of the National Health Service.

The functions of child welfare centres in the 1960's are not necessarily those appropriate to a byegone era. The relative importance of the different tasks has altered. Today their functions are:

(1) Education of the family, via the mother, in babycraft.

(2) Advice on infant feeding and management.

(3) Observation of the child's development—(*a*) physical, (*b*) mental, (*c*) environmental, with particular reference to congenital diseases. (It is not the function of a child welfare centre to look specifically for acute illness; when such illness is found it is essential that appropriate action is taken, though it would be wrong to consider this as even a subsidiary function of the welfare centre.)

(4) Routine vaccination and immunization.

(5) Supply of welfare foods.

(6) A case can be made out for transferring the first school examination to the previous year, i.e., it should be done in the child's fifth year as his ' farewell ' to the welfare centre. By this means many disabilities necessitating special education facilities could be detected in time for the child to be sent to an appropriate school in the first instance. The advantage of this arrangement is that the doctor at the welfare centre, assisted by the health visitor, would be able to incorporate into the report their experience of the child's first four years' development.

(7) Relatively recently, emphasis has been placed upon the need for special supervision of vulnerable groups of children. This indicates another function for the child welfare centre, and it may well be that in the future, other comparable duties will be found for the child welfare centres.

(8) Another function, at present performed by some welfare centres, whether held by the general practitioner in his consulting room, or the local authority in theirs, is to act as a focal point for the mutual exchange of information; the health visitor and the general practitioner providing each other with parts of the jigsaw which gives a picture of the child for whom they are both responsible.

It is essential to see the eight functions listed above as distinct entities, however intertwined they may become in practice. Examining a child with a stethoscope or weighing it when it attends for immunization, is not an adequate substitute for a routine physical check-up, carried out with the specific purpose of looking for congenital or early acquired diseases and abnormalities. These routine inspections are time-consuming and require a particular skill.

Lastly, there is a major need for a central correlating body to maintain relevant records and be responsible for supervision and follow-up of all pre-school children to ensure that the facilities available are offered to the mother for her baby. Already in some areas, and indeed in the fullness of time throughout the country, the activities at present undertaken within the building of a local authority child welfare centre will be transferred to the ' consulting rooms ' or ' clinics ' of general practitioners. When this occurs there will still be a need for an administrative centre for the local authority, where, to use a service expression, the child appears ' on paper '.

Staffing the child welfare centres

This could be considered in three parts:

(1) Medical
(2) Health visitor
(3) Ancillary (principally clerical)

It is assumed that one or more health visitors are attached to each child welfare centre.

There should be a doctor present at most sessions. If the clinics are held in the general practitioner's building, then experience in such a situation has shown that the health visitor can sometimes do a session on her own, if this session immediately precedes a consultation session conducted by the general practitioner. If the health visitor sees a child in need of

urgent medical care, she asks the mother to wait until the doctor arrives. Where such health-visitor sessions are held, it is customary—indeed essential—that the general practitioner and the health visitor should also hold combined sessions on other days.

The doctor at a child welfare centre could be:

(1) A general practitioner
(2) Local authority medical officer
(3) A paediatrician

A case could be made for any one of these three to be the normal medical attendant, for each has his own particular advantages. Few paediatricians at present conduct their own welfare clinics except in a consultative capacity, and we are here dealing with the staffing of routine sessions. There is much to be said for paediatricians holding their own regular sessions at clinics, and there is no real reason why a paediatrician should not share a clinic with a general practitioner in the latter's practice accommodation: both would undoubtedly benefit. However, the relative numbers of paediatricians to babies' welfare clinics is such that the paediatricians could, even if they wanted otherwise, only take a very small share in the work-load.

The pyramid of the local authority services is likely to acquire a much narrower base in the future which means, in effect, that there will be fewer assistant medical officers to run welfare clinics. We believe that every medical officer of health should have experience of running these clinics himself, certainly in his earlier years in public health work. We do not, however, believe that the majority of clinics should be run, wherever they are to be held, by assistant medical officers, either full-time or part-time.

The general practitioner has a continuous responsibility for the child throughout its development, and provided he has the training and inclination, he is the best person to be in charge of most welfare clinics.

In an ideal health service, general practitioners will be working in groups, large or small, from accommodation which would be adequate also for the needs of a welfare centre. The general practitioners should have adequate time—and training—to run special clinics for the babies in their practice and the local authority would provide the necessary secretarial facilities and ancillary staff to assist at the clinic and arrange follow-ups. One or more health visitors would share in the running of the clinic which would be a natural function to them as they would be members of the practice.

On the other hand, we concede that not all general practitioners at present have an interest in child welfare or have had (or would wish to undertake) the requisite training. We further concede that group medical centres are unlikely to be universally possible (for financial and administrative reasons) for some time. Some are already in existence and we have no doubt that their number will be multiplied. Provision will still have to be made for those babies under the care of general practitioners who will not have these facilities or the interest referred to. It would be wrong, on ethical and every other ground, to compel babies to be registered

with general practitioners who have a paediatric interest. It is equally wrong for children registered with general practitioners who have welfare sessions in the practice to be seen at a local authority clinic.

As we cannot conceive of a uniformity within the medical services of this country, we would suggest that there is a need for welfare centres within general practice and welfare centres provided by the local authority in buildings owned by the local authority.

The local authority clinics would provide the service for those babies who would otherwise not get the necessary supervision. As the general-practice medical/health/welfare centres become universal in a neighbourhood, the local authority clinics would be closed down. (We have no doubt that suitable alternative uses could be made for these buildings.) The extension of the system whereby the health visitor is attached to a group of general practitioners—either a group sharing one set of premises or several groups occupying different premises—is an essential prerequisite to future planning. The list of a health visitor should be directly related to the list of the general practitioner with whom she works and need not be restricted by street or other geographical boundaries.

Most of the other problems of staffing at welfare centres are related to the question of who is responsible for cost. Within the present framework, the local authorities should be responsible for the provision of not only the health visitor, but also all the ancillary staff necessary for the running of a welfare centre. Therefore, it would seem logical that the local authority should pay an appropriate portion of the salary of the ancillary staff employed by individual practices. As it is possible that a greater degree of co-ordination within the three limbs of the Health Service is likely to be seen in the future, it would not be worth elaborating this point.

Agricultural Tractor Accidents. W. D. REES. *Brit. med. J.* 1965. **2**, 63.

Fourteen tractor accidents occurring in the area of a rural general practice in Montgomeryshire are described—three of them fatal.

Tractor accidents tend to have a much higher mortality and serious injury rate than road traffic accidents. Only one of the accidents reported resulted in ' slight ' injury, the remaining 13 being serious or fatal.

It is estimated that if the driver is injured when a tractor overturns the chances of the injury being fatal are about 25 per cent.

Approximately 50 people are killed annually in tractor accidents in England and Wales. Strong safety frames or cockpits should be provided on tractors to give more protection to drivers.